Supreme Court, U.S.
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No. 01-1399

In the Supreme Court of the United States

UNITED STATES OF AMERICA, EX REL.
JACK OBEYDEAN SWAFFORD, A/K/A DEAN J. SWAFFORD,
Petitioner,

v.

BORGESS MEDICAL CENTER,
A NONPROFIT MICHIGAN CORPORATION, ET AL.,
Respondents.

ON PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

RESPONDENT'S BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED FOR REVIEW

1. Whether in the absence of a circuit split or departure from Supreme Court precedent, this Court should review the District Court and Sixth Circuit decisions that mere non-compliance with health care regulations or a requisite standard of care is insufficient on its own to establish "falsity" under the False Claims Act.

2. Whether in the absence of a circuit split or departure from Supreme Court precedent, this Court should review the District Court and Sixth Circuit decisions that the ultrasound reports in this case were not knowingly fraudulent.

CORPORATE DISCLOSURE STATEMENT

Pursuant to Supreme Court Rule 29.6, Respondent Borgess Medical Center makes the following disclosure:

Borgess Medical Center is a non-profit corporation. No publicly-owned corporation owns stock in Borgess Medical Center.

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RESPONDENT BORGESS MEDICAL CENTER'S STATEMENT OF THE CASE

This is a qui tam action brought pursuant to 31 U.S.C. § 3729-3731, known as the False Claims Act (hereinafter, "FCA"). Petitioner alleges that Respondents have submitted false claims to the federal government for Respondent physicians' reading and interpretation of venous Doppler ultrasound tests conducted on patients who were participants in federal health care programs. These tests are designed to assist in the diagnosis of deep vein thrombosis ("DVT") or blood clots in the arms and legs.

Petitioner's statement of the proceedings below in this case is accurate. Pet. at 4. However, Respondent Borgess Medical Center wishes to describe the ultrasound studies which provide the basis for Petitioner's claim, as Petitioner's description of these studies is misleading.

Understanding the way in which venous ultrasound studies are performed is crucial to this case. For patients suspected of suffering from risk factors for blood clots, defendant physicians would order a venous ultrasound study. Using ultrasound, the patient's venous system would be examined to determine the presence or absence of certain "normal" characteristics for five blood clot risk factors. Either a technician or a technologist would typically perform the ultrasound study, and would indicate the presence or absence of the five factors on a worksheet. The worksheet was then given to a physician for review and interpretation.

Although the five factors of the studies are focused on obtaining a "negative" or "positive" finding, the overall results of the studies include significant variations from patient to patient. Some studies are incomplete because of

limitations on the technician's ability to test all of the areas required; some studies indicate evidence of non-blood clot related pathologies or abnormalities; some studies show "positive" characteristics consistent with the presence of acute blood clots; and some studies reveal no abnormalities whatsoever.

Technicians are highly skilled in performing the studies. However, more than technical knowledge is required to understand the medical significance of these variations. Consequently, vascular surgeons would review every test–from simple to complex–to ensure that the results were evaluated by a physician qualified to see the medical significance of the various possible outcomes.

In those cases where technicians found abnormal responses–described as a test that is "positive" for possible DVT–the physicians reviewed the videotape (or still photographs derived from the videotape) of the ultrasound test. In cases where the technicians found normal responses–a so-called "negative" test for possible DVT–videotapes or stills were not routinely reviewed. Where the technicians found normal responses, but other abnormalities existed, the vascular physicians might or might not review the videotapes or stills, depending on the abnormality.

Petitioner characterizes as "plagiarism" the physician reports which were based on technician worksheets alone, where physicians did not deem the review of videotapes or stills necessary. Pet. at 3. Petitioner bases his FCA claim on this alleged "plagiarism."

REASONS FOR DENYING THE WRIT OF CERTIORARI

I Petitioner's argument for the importance of the instant case is unpersuasive.

Rule 10 of the Supreme Court Rules indicates "the character of the reasons the Court considers" when reviewing a petition for certiorari. SUP. CT. R. 10. The reasons applicable to this case are:

> (1) a conflict between United States courts of appeals on an important matter,
>
> (2) an unusual departure from the accepted course of judicial proceedings warranting an exercise of supervisory power,
>
> (3) a United States court of appeals has decided an important federal question in conflict with relevant Supreme Court jurisprudence, and
>
> (4) a United States court of appeals has decided an important question of federal law that has not been, but should be, settled by this Court.

SUP. CT. R. 10 (a), (c).

Importantly, Petitioner in this case does not allege a circuit split or a conflict with Supreme Court jurisprudence; this case clearly involves neither. Petitioner argues somewhat implicitly that this case involves an important question of

federal law that has not been but should be settled by this Court. Unfortunately for Petitioner, the content of this important federal question is never made clear in the Petition.

In arguing for the "importance" of this case, Petitioner first cites Wright and Miller's *Federal Practice and Procedure* for the proposition that summary judgment is disfavored in matters involving important public issues. Pet. at 5. However, to argue that review is appropriate for any case dismissed on summary judgment which involves an important public issue would be to cast the net of discretionary review wide indeed. Even if it were generally accepted that summary judgment is disfavored in matters involving important public issues, the question should be why the Court should review *this particular* case dismissed on summary judgment below. Petitioner offers no answer to this question.

Petitioner next argues that this case merits review because the "the detection and eradication of health care fraud and abuse is [sic] a top priority of federal law enforcement." Pet at 6 (citing *The Department of Health and Human Services and The Department of Justice Health Care Fraud and Abuse Control Program Annual Report for FY 1998*). This proposition is uncontroversial. And yet, it too fails to provide a basis for granting review. For to state that this case involves a matter that is a top priority of federal law enforcement is not to distinguish this case in any way from hundreds of others, all of which cannot be reviewed by this Court. To grant review to all cases involving health care fraud–even cases which were dismissed on summary judgment below–would all but eviscerate this Court's discretionary review.

Perhaps recognizing the over-inclusiveness of his first two arguments, Petitioner next attempts to articulate a more specific question of federal law deserving review. As explained in more detail in Section III below, Petitioner in this case claims that the services for which Respondent physicians billed for the reading of "negative" DVT studies fail to meet the definition of "physician's services," as defined by applicable federal regulations and by the applicable medical standard of care. Petitioner specifically finds fault with vascular physicians' use of Medicare billing codes with "26 modifiers" when billing for the services at issue in this case. "26 modifiers" indicate that the physician delivered the "professional," as distinct from the "technical" component of the test. In Petitioner's view, the claims in this case were "false" or "fraudulent" because vascular physicians did not provide any service, "professional" or otherwise, in reading the negative DVT studies.

In this context, Petitioner urges this court to grant review because: "THERE IS NO RELEVANT PRECEDENT FOR INTERPRETING HEALTH CARE BILLING CODES, WHERE NO DEFINITION HAS BEEN PROVIDED BY THE FEDERAL GOVERNMENT." Pet. at 7. (emphasis original) Without the review requested, Petitioner argues, health care providers will "continue" with impunity to bill the federal government for services that do not meet the definition of such services in the healthcare community. *Id.* at 8.

First, Petitioner's argument misconstrues the role of this Court. Petitioner appears to request that this court grant a writ of certiorari in order to give guidance on the definition of such terms as "physician services," "professional services," and/or "reading" and "interpretation" of test results. These terms are, by Petitioner's own account,

defined by a number of federal rules and regulations. *See* Pet at 17.[1] To the extent that these definitions are problematic, it is the role of the executive and the legislative branches, not the judiciary, to amend the relevant regulations.

Second, Petitioner's argument undermines his allegation elsewhere that the claims involved in this case were "false" in any relevant sense of the word. Petitioner asserts that the federal government has provided no meaningful guidance on the use of certain billing codes and terms used to describe the services rendered in this case (e.g. "physician services," "professional services"). Pet. at 7. Petitioner consequently urges this Court to provide guidance on these codes and terms. *Id.* But how can Petitioner allege that Respondent's requests for payment for physician or professional services were "false" or "fraudulent" where the terms "physician" and "professional services" were nowhere clearly defined? In other words, how can Respondent have known, in any actionable sense, that physicians were not performing billable services, when there was no accepted definition of what billable services actually were? In essence, Petitioner asks the Court to grant review in order to define Medicare billing terms, so that Respondent may, *ex post facto*, be held responsible for understanding and disregarding these definitions when billing. Such a request is hard to understand.

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[1] Petitioner below urged the application of the Health Care Financing Administration's Carriers Manual, and several alternative regulations. The District Court found that none applied to this case. *See* District Court Opinion, Pet's App. A at 11a-12a (42 C.F.R. § 415; 60 C.F.R. § 63142; 42 C.F.R. §§ 415.102, 415.120, 415.130, 1395; and 60 C.F.R. § 63130-63133 not applicable).

Finally, Petitioner complains of an alleged discovery error in the District Court. Petitioner's argument is meritless, for the reason explicated in Section II below.

At bottom, Petitioner cannot generate importance where none exists. While the instant case deals with alleged health care fraud, and was dismissed on summary judgment below, these features do not in and of themselves make this case appropriate for review. Nor does the speculation that review of this case could--or should--provide regulatory guidance in the health care arena. Because Petitioner does not carry his burden of demonstrating any important federal question, or demonstrating that the case should be reviewed on any other grounds, Respondent requests that the writ of certiorari be denied.

II The District Court's alleged discovery error did not prejudice petitioner's case.

To prevail under the FCA, a plaintiff must establish: (1) that the defendant knowingly presented a claim to the United States for payment or approval; (2) that the claim was false or fraudulent; and (3) that the defendant "knew" that the claim was false or fraudulent. 31 U.S.C. §3729(a).[2]

Petitioner alleges that he was not permitted to conduct discovery on the issue of the third element, whether the

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[2] The first element, the submission of a claim, has never been in dispute in this case. The second and third elements have been in dispute, and shall be discussed in Sections III and IV below, respectively.

defendant "knew" that the claim was false or fraudulent. This element is commonly called the "scienter" element. Specifically, Petitioner alleges that the District Court, by Order of March 29, 1999, *see* Pet's App. D, directed the parties to embark on an "initial" phase of discovery dealing only with the physicians' interpretation practices. The District Court then went on to grant plaintiff summary judgment in part on the grounds that Petitioner had failed to make a showing of scienter, that is, of "reckless disregard" or "deliberate ignorance" with respect to the falsity of its claims. Pet. at 9 (citing District Court Opinion, Pet's App. A at 22a).

This alleged discovery error objection can be disposed of summarily. Even if the District Court erred in making findings regarding scienter (which Respondent in no way concedes), the District Court's summary judgment relied not merely on Petitioner's failure to demonstrate a genuine issue of material fact with respect to scienter but also–in fact, predominantly–on Petitioner's failure with respect to the second element of a FCA claim, falsity. In fact, the District Court opinion discusses the second element of the case, falsity, for nearly twelve pages, and the third element, scienter, for fewer than three. *See* District Court Opinion, Pet's App. A at 21a-23a (scienter) 9a-21a (falsity).

The District Court's so-called "error," even if substantiated, would therefore not affect the outcome of this case, and should be of little consequence to this Court. *See* FED. R. CIV. P. 61; 28 U.S.C. § 2111 ("On the hearing of any appeal or writ of certiorari in any case, the court shall give judgment after the examination of the record without regard to errors or defects which do not affect the substantial rights of the parties."); *Mraovic v. Elgin, Joliet & Eastern Ry. Co.*, 897 F.2d 268, 271 (7th Cir. 1990) (medical expert's testimony excluded but harmless since jury found no liability

and never got to damages aspect of case). Petitioner's argument that review should be granted based on a discovery error should thus be rejected.

III The District Court did not err in its decisions regarding the "falsity" of Respondent's claims.

With respect to the second element of the FCA, that the submitted claims were false or fraudulent, Petitioner faults the District Court for relying on two premises Petitioner considers erroneous:

> (1) that "the federal government had not published rules and/or regulations relative [sic] to the Respondents," and
>
> (2) that in establishing "falsity" under the False Claims Act "reference to the attending Standard of Practice was irrelevant."

Pet. at 12. Petitioner argues that these erroneous premises allowed the District Court to conclude that there was no genuine issue of material fact with respect to falsity. Pet. at 12.

A. The Inapplicability of Federal Regulations

Petitioner fails to realize that the first premise, even if erroneous, was not necessary to, and therefore does not undermine, the District Court's summary judgment for Respondent Borgess Medical Center. Petitioner is correct that the District Court found that the the Health Care Financing Administration's Carriers Manual, and several alternative regulations cited by Petitioner, did not apply to the

instant case. *See* District Court Opinion, Pet's App. A at 11a-12a (42 C.F.R. § 415; 60 C.F.R. § 63142; 42 C.F.R. §§ 415.102, 415.120, 415.130, 1395; and 60 C.F.R. § 63130-63133 not applicable). However, the District Court went on to hold that, even if these regulations governed Respondent's conduct, the "FCA is not an appropriate vehicle for policing technical compliance with administrative regulations," and that "[m]ere violations of administrative regulations are not actionable under the FCA 'unless the violator knowingly lies to the government about them.'" District Court Opinion, Pet's App. A at 12a (quoting *U.S. ex rel. Lamers v. City of Green Bay*, 168 F.3d 1013, 1020 (7th Cir. 1999)).

Thus, the District Court opinion shows that summary judgment regarding falsity did not depend upon the inapplicability of the regulations cited by Petitioner. Rather, the District Court depended upon the unassailable legal proposition that regulatory non-compliance does not constitute "falsity" under the FCA.[3]

Petitioner's analysis of the applicability of certain regulations is an attempt to distract the Court from this unassailable proposition. As indicated above, the District Court relied upon *Lamers* in support of this proposition. But there are many more cases offering support. *See Luckey v. Baxter Healthcare Corp.*, 183 F.3d 730, 733 (7th Cir. 1999) (holding that defendant had not violated any regulation, but

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[3/] Petitioner cites *Jones v. United States,* 121 F.3d 1327 (9th Cir. 1997), in support of the proposition that "publication [of regulations] in the Federal Register is legally sufficient notice to all interested or affected persons regardless of actual knowledge or hardship resulting from ignorance." Pet. at 17 (citing *Jones*). Because violation of regulations, noticed or not, does not constitute "falsity" under the FCA, this line of analysis is not fruitful.

even if he had, "technical violations of a federal regulation on which a claim is based do not make the claim 'false'"); *U.S. ex rel. Hopper v. Anton*, 91 F.3d 1261, 1267 (9th Cir. 1996) ("Mere regulatory violations do not give rise to a viable FCA action."); *U.S. ex rel. Mikes v. Straus,* 84 F.Supp. 2d 427, 435-6 (S.D.N.Y. 1999) (rejecting plaintiff's theory that falsity could be based on defendant's non-compliance with a Medicare regulation).

Notably, Petitioner nowhere finds fault with the District Court's reliance on the rule for which these cases stand, despite the fact that it was this rule–and not the inapplicability of certain regulations–that was fatal to Petitioner's FCA claim in the District Court. Instead, Petitioner attempts to generate interest in this case by focusing on an issue on which there may be controversy, but which is not even arguably dispositive. Petitioner's attempt is transparent, and is not a proper basis for granting review.

B. The "Irrelevance" of the Standard of Care

The second premise with which Petitioner takes issue is that the District Court supposedly found "reference to the attending Standard of Practice was irrelevant" to a finding of falsity under the FCA. Pet. at 12. Petitioner argues that "[c]ontrary to the conclusion of the district court[,] reference to the attending Standard of Practice can be utilized to determine the falsity of a claim." Pet. at 21. Petitioner cites one case, *U.S. v. NHC Healthcare Corp.*, 115 F.Supp. 2d 1149 (W.D. Mo., 2000), in support of this proposition

Even a cursory reading of the District Court opinion in the instant case indicates that Petitioner has grossly mistated the District Court's decision with respect to the standard of care. Nowhere does the District Court state that

the standard of care or standard of practice in the medical community would be "irrelevant" or unimportant to a FCA claim brought in the context of patient care. Rather, the District Court opinion relies on the very different proposition, amply supported in case law, that claims that merely fail to meet the relevant standard of care are "insufficient" to establish falsity under the FCA. District Court Opinion, Pet's App. A at 16a-19a (citing *Luckey v. Baxter Healthcare Corp.*, 183 F.3d 730 (7th Cir. 1999); *Hagood v. Sonoma County Water Agency*, 81 F.3d 1465, 1478 (9th Cir. 1998); *United States ex. rel. Hopper v. Anton*, 91 F.3d 1261 (9th Cir. 1996); *United States ex rel. Thompson v. Columbia/HCA Healthcare Corp.*, 125 F.3d 899 (5th Cir. 1997); *U.S. ex rel. Mikes v. Straus*, 84 F.Supp 2d 427 (S.D.N.Y. 1999) ("submitting a claim to the Government for a service that was not provided in accordance with the relevant standard of care, however, without more, does not render that claim false or fraudulent for FCA purposes."))

The proposition that the standard of care is "irrelevant" to falsity and the proposition that non-compliance with the standard of care is insufficient to establish falsity are entirely distinct. But again, Petitioner attempts to generate interest in this case by pretending there is controversy where there is not. By mischaracterizing the District Court's conclusion regarding the standard of care, Petitioner paints the picture of a district court as impractical as it is overreaching, for to find that the applicable standard of care is entirely irrelevant to FCA claims involving patient care would be strange indeed. In fact, Petitioner attacks a straw man, for the District Court never states that the standard of care is irrelevant.

As mentioned above, in the context of this attack, Petitioner cites *U.S. v. NHC Healthcare Corp.*, 115 F.Supp.

2d 1149 (W.D. Mo., 2000) in support of the proposition that "reference to the attending Standard of Practice can be utilized to determine the falsity of a claim." Pet. at 21. Although Petitioner quotes *NHC* selectively, a more thorough reading of *NHC* hurts Petitioner more than it helps him.

In *NHC*, the government argued that the defendant nursing home was so severely understaffed that it could not possibly have administered all of the care it was obligated to perform under the Medicare and Medicaid programs for two nursing home residents for whose care the home had billed the government. The District Court for the Western District of Missouri held that plaintiff could state a claim for false or fraudulent billing for the two residents where they "were not provided the quality of care which promotes the maintenance and the enhancement of the quality of life." *NHC Healthcare*, 115 F.Supp.2d at 1152.[4]

What Petitioner fails to mention about *NHC* is that the opinion in that case takes pains to distinguish the main issue there--whether services such as bathing, turning, and administering drugs to patients were performed *at all*, under any definition of those terms--from the main issue of cases such as the instant one, where plaintiffs allege that services, which were admittedly performed, were not performed within the parameters set by the relevant standard of care.[5]

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[4] The court admitted that this was "an amorphous standard in need of further clarification," *id.*, but stated that at that stage in the litigation, a motion to dismiss for failure to state a claim, plaintiff need only plead a sufficient cause of action. *Id.*

[5] *NHC* utilizes *U.S. ex rel. Mikes v. Straus, supra,* and *U.S. ex rel Aranda v. Community Psychiatric Centers of Oklahoma, Inc.* 945

The *NHC* case articulates this crucial distinction in two helpful ways. First, the court explains:

> While the standard of care is raised in [those cases] and in the present case, it is discussed for differing reasons. In [those cases] the Plaintiff alleges that the mere violation of the standard of care, followed by billing Medicare for the defective procedures, was a violation. Conversely, in this case the Government utilizes the standard of care as a measuring stick to demonstrate that *not all necessary medical acts that were billed for were actually performed*.

NHC, 115 F.Supp 2d at 1155, n. 4 (emphasis added).

Second, the *NHC* court explains, "[t]he billing dispute at issue here is not *how* the Defendant turned, bathed, administered drugs to, and fed the two residents in question, but *whether* the Defendant did these things at all." *Id.* at 1155 (emphasis original).

Clearly, the case at bar falls into the former category in both of these contrasting pairs. As the District Court pointed out, Petitioner in this case does not claim that vascular physicians did not perform any services at all. Instead, he claims that when physicians reviewed the "negative" DVT worksheets they did not perform services "in any reasonable sense or meaning of the word." District Court Opinion, Pet's App. A at 19a-20a (citing Pla's Brief at 9).

F.Supp. 1485 (W.D. Okla. 1996) as examples of the latter type of case.

Thus, Petitioner is correct that *NHC* stands for the proposition that the applicable standard of care can be highly relevant to finding falsity under the FCA. However, the central holding of *NHC* is that if the violation of the standard of care results in no services being provided, a FCA claim may be stated, but not, as in the instant case, where the argument is that the services actually provided were merely inadequate. Ultimately, Petitioner's attack of the District Court's decision regarding the standard of care, including his reliance on *NHC,* is ineffective.

IV There is no question that the District Court employed the correct *scienter* standard under the False Claims Act.

Quite apart from Petitioner's claim that the District Court erred in making findings on scienter, as explained in Section II above, Petitioner argues that the District Court erred by employing an incorrect legal standard for scienter under the FCA. Pet. at 24-27. According to Petitioner, "[w]hereas the statute does not require a specific intent to defraud[,] the trial court did." *Id.* at 25.

Petitioner's argument is at best careless and at worst disingenuous. Petitioner specifically finds fault with the following portion of the District Court opinion:

> . . . to prevail under § 3729(a), a plaintiff must establish at least three elements: first, that the defendant knowingly presented or caused to be presented a claim to the United States for payment or approval; second, that the claim was false or fraudulent, and third, that the defendant knew the claim was false or fraudulent.

Pet. at 25 (citing District Court Opinion and Order of February 18, 2000, Pet's App. A at [9a]) (emphasis added by Petitioner). Petitioner insists, "IT WAS ERROR FOR THE TRIAL COURT TO HOLD THAT THE STANDARD WAS THAT THE 'DEFENDANT KNEW THAT THE CLAIM WAS FALSE.'" Pet. at 25 (emphasis in original). Rather, according to Petitioner, the District Court should have recognized that under the FCA,

> "knowing" and "knowingly" mean that a person, with respect to information–(1) has actual knowledge of the information; (2) acts in deliberate ignorance of the truth or falsity of the information; or (3) acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required.

Pet. at 26 (citing *US v. Mackby*, 243 F.3d 1159, 1165 (9th Cir. 2001).

What Petitioner fails to tell this Court is that in the section of the District Court opinion dealing with scienter, the District Court goes on to recite–and apply–exactly the standard cited approvingly by Petitioner above. District Court Opinion, Pet's App. A at 21a ("The Act's scienter requirement is set forth in §3729(b), which requires either 'actual knowledge' that one is submitting a false or fraudulent claim for payment or approval, acts in deliberate ignorance of the truth or falsity of one's false claim, or 'acts in reckless disregard of the truth or falsity of the claim." (citing *Wang v. FMC Corp.*, 975 F.2d 1412, 1420 (9th Cir. 1992)). In fact, the District Court explicitly states, "To succeed under the FCA, a relator need not demonstrate specific intent to defraud

the government." District Court Opinion, Pet's App. A at 21a.

Presumably, Petitioner has overlooked this section of the District Court opinion, or he would have hesitated to make the argument that the District Court used an incorrect scienter standard. Whatever the explanation for Petitioner's argument, the District Court used the proper scienter standard, and there is no error to review.

V The Court of Appeals did not err in its use of the *Hagood* and *Hindo* cases to support its affirmance of the District Court.

As Petitioner correctly explains, the United States Court of Appeals for the Sixth Circuit affirmed the District Court's grant of summary judgment for defendants in this case in a seven-sentence, unpublished *per curiam* opinion. Pet's App. B. That opinion cites two cases in support of affirmance: *Hagood v. Sonoma County Water Agency*, 81 F.3d 1465 (9th Cir. 1996) and *Hindo v. University of Health Sciences*, 65 F.3d 608 (7th Cir. 1995). Petitioner argues that the Sixth Circuit's reliance on each was misplaced. However, because Petitioner merely highlights obvious factual differences between these cases and the instant case, without explaining why these differences call into question those cases' applicability, this argument should be rejected.

Petitioner's sole complaint about the use of *Hagood* is that the case does not involve issues of "standard of care," and that the Sixth Circuit nonetheless cites the case in support of the proposition that "[s]ervices falling below a requisite standard of care, without more, is insufficient to state a claim for government reimbursement of venous ultrasound testing

services." Pet. at 27 (citing Opinion of Court of Appeals, Pet.'s App. B). Petitioner points out that *Hagood* dealt not with health care issues, but with the building of a dam--specifically, with the Sonoma County Water Agency's reliance on a cost allocation report prepared by the Army Corps of Engineers when the Agency provided figures to the government, resulting in the government under-billing the Agency for its water usage.[6]

The Sixth Circuit's reliance on *Hagood* is unsurprising. In that case, the Ninth Circuit concluded that the Agency's reliance on the Corps' cost allocation figures was not "false" within the meaning of the FCA because the allocation figures were a disputed legal question within the Corps. *Hagood*, 81 F.3d at 1477. Similarly, in the instant case, the question whether vascular physicians met the relevant standard of care when reading and interpreting negative DVT studies is, at the most, a matter of legal and medical debate, given the ambiguity of the terms "read" and "interpret" in the Health Care Financing Administration's Provider Handbook and elsewhere. *See* District Court Opinion, Pet's App. A at 20a. The Sixth Circuit thus correctly relies upon *Hagood* because it illustrates that "falsity" must be based on something more than mere definitional disputes. Consequently, submitting claims for reading and interpreting these studies cannot be considered "false" or "fraudulent." Thus, the analogy between *Hagood* and the instant case is apt.

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[6] The *Hagood* court characterizes the case as a "reverse" false claims case insofar as defendant's representations to the government did not result in improper payments to defendant, as in the usual false clams case, but instead in the federal government's underbilling of defendant.

Petitioner's argument with respect to *Hindo* is equally unconvincing. Petitioner distinguishes *Hindo* and the instant case on the sole ground that in *Hindo* there was no question that radiology resident physicians provided the health care services they had contracted to provide, while in the instant case there is a question whether the physician's reading and interpretation of technician's DVT worksheets, and subsequent preparation of a report, constituted "physician services" in any meaningful sense of the word. Pet. at 29.

This distinction is insignificant. It is true that, in *Hindo*, the alleged false claim did not center on the nature of services performed by radiology resident physicians. Rather, that case involved the residents' medical school submitting to the Veterans Administration ("VA") hospital a claim for reimbursement of the salaries of the school's radiology residents who worked at the hospital. The medical school had paid the residents with the understanding that the hospital might obtain funding for the salaries and subsequently reimburse the school. The hospital mistakenly paid the medical school's claim. Plaintiff alleged that the school submitted the claim "falsely"–that is, knowing that the hospital had not received funding, and yet hoping for payment through the hospital's oversight. Plaintiff presented no evidence of fraudulent intent by the school.

The Seventh Circuit decided that the medical school's billing of the VA hospital was not "false" within the meaning of the FCA because the school "could safely assume that if funding had become available, it would be repaid; if the funding had not been approved, it would not be repaid for the residents. . . .[W]hen the University invoiced the radiology residents' costs, the Medical Center was in the best position to ascertain whether funding had been obtained." *Hindo*, 65 F.3d at 614.

Like its reliance on *Hagood*, the Sixth Circuit's reliance on *Hindo* is unremarkable. *Hindo* informs the outcome of the instant case because it involves the question of whether it is knowingly fraudulent to submit claims for which defendants believe, in good faith, payment may be appropriate. Petitioner's objection to the application of *Hindo*, therefore, on the grounds that the cases are factually different, rings hollow.[7]

Petitioner's attempt to manufacture error at the appellate level, like his corresponding effort at the trial court level, is unsuccessful.

CONCLUSION

For the reasons stated above, Respondent respectfully requests that the Petition for a Writ of Certiorari be denied. Petitioner alleges no circuit split or decision in conflict with Supreme Court jurisprudence, and Petitioner's argument for the national importance of this case is extremely weak. Furthermore, the decisions below are based upon clear precedent that even if Respondent had violated applicable regulations or failed to comply with the relevant standard of care–which it did not–these do not alone establish "falsity" under the FCA.

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[7] In fact, it appears that Petitioner would benefit from a more careful reading of *Hindo*. Petitioner implies that it was the VA hospital, and not the medical school, that was accused of violating the FCA. *See* Pet. at 28-9 ("The problem in *Hindo, supra*, rather was that the VAMC [i.e. VA Medical Center] never successfully obtained funding for the services it accepted.") Petitioner's confusion regarding the parties' roles in *Hindo* does not inspire faith in his analysis of the case.

Petitioner's overriding argument throughout these proceedings has been that defendants did not "read" or "interpret" ultrasound studies within any reasonable meaning of those words. However, as this Court will surely recognize, to call defendants' actions "fraud" within the terms of the FCA would be appropriate "[o]nly in Humpty Dumpty's world of word games. . . " *Luckey*, 182 F.3d at 732. "Perhaps [Petitioner] could persuade the [Health Care Financing Administration] to require more or different testing; but when," as in this case, Petitioner "complies with the existing regulations, it is entitled to represent to the government (and the world) that it has done so, without facing a claim of deception." *Id.*

Respectfully Submitted,

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